

THE JOURNAL OF
THE ROYAL COLLEGE
OF GENERAL PRACTITIONERS

Volume 37



INDEX

INDEX FOR VOLUME 37

January	Number 294	pages 1–48
February	Number 295	pages 49–96
March	Number 296	pages 97–144
April	Number 297	pages 145–192
May	Number 298	pages 193–240
June	Number 299	pages 241–288
July	Number 300	pages 289–336
August	Number 301	pages 337–384
September	Number 302	pages 385–432
October	Number 303	pages 433–480
November	Number 304	pages 481–528
December	Number 305	pages 529–576

Abbreviations

- C — Correspondence
E — Editorial
N — News

Subject Index

A

Academic general practice: *see also* Universities
Contribution to care and research, RH Davis 196–198
Identity of, M Marinker (E) 385–387
Accidents: lavatory door and (C) 275
Acquired immune deficiency syndrome: *see* AIDS
Acupuncture: *see* Alternative medicine
Adolescents: gynaecomastia (C) 178
Aged: *see* Elderly
Age–sex registers in general practice (C) 560
AIDS:
Attitudes to patients with, RTA Scott (E) 529–530
College response to Social Services Committee (N) 90
Conference (N) 234–235
Educational course (C) 511
General practitioners and care of patients with, (E) 289–290, (C) 418
General practitioners in care of (C) 273
Patient knowledge about (C) 510–511
Rehabilitation unit for drug abusers (C) 131
Students' awareness of and attitudes to, JS Brown *et al* 457–458
Alarm system for the elderly, M McWhirter 244–247
Alcohol:
Evaluation of intervention for problem drinkers (DRAMS), N Heather *et al* 358–363, (C) 511
In pregnancy, health education, A McKnight and D Merrett 73–76
Patterns of consumption, PG Wallace *et al* 354–357, (C) 513
Allergies: treatment for hay fever, MF D'Souza *et al* 296–300
Alternative medicine:
Acupuncture for common disorder, review of research, CA Vincent and PH Richardson 77–81
Hypnosis for childbirth compared with relaxation, LR Brann and SA Guzvica 437–440
Survey of doctors' views, E Anderson and P Anderson 52–55, (C) 224–225, (C) 369–370, (C) 461
Anaphylactic shock reaction to measles vaccine (C) 41
Anatomy and art: Dr William Hunter, A Darlington (N) 144
Ancillary staff:
Practice receptionist programme (N) 574
Reimbursement of (C) 323
Annual reports: from general practices, AS Urquhart (E) 148
Antenatal care: integrated community clinic, H Thomas *et al* 544–547
Antibiotics: prescribing in young children, parental expectations (C) 42
Anus: chicken bone and pain in, N Carr 314
Anxiety:
Long-term tranquillizer users, JV Salinsky and CJ Doré 202–204, (C) 320–321
Management of, linking professionals and self-help, CG Long and V Bourne 199–201
Appointments:
RCS Medical School Dublin professor of general practice: W Shannon (N) 279
Stuart faculty fellow: J Donald (N) 576
Stuart research associates: J Read, C Connolly, P Elliot, N Westhead, P Bradley (N) 138
University College and Middlesex professor of primary care: A Haines (N) 48
Asperger's syndrome: case report, CM Goodman 414–415
Aspirin: Reye's syndrome and parents' knowledge, RW Hall 459–460
Assessment, educational: *see* Education

Atrial fibrillation: prevalence of in elderly, JD Hill *et al* 172–173
Attendance allowance: clarification of article in *Members reference book* (C) 562
Audit:
Employing a medical student for (C) 272
Epilepsy in a practice over eight years, MP Taylor 116–119
Medical centre for the homeless, PD Toon *et al* 120–122, (C) 320
Preventive care, using a computer (C) 272–273
'Rent-an-audit' (C) 177

B

Behaviour of general practitioners, role models (C) 85
Benzodiazepines: characteristics of long-term users, JV Salinsky and CJ Doré 202–204, (C) 320–321
Bereavement: risk factors for mortality after, A Bowling and J Charlton 551–554
Bone and joint problems: National Osteoporosis Society symposium (N) 331
Books reviewed:
14 Princes Gate (J Horder and S Pasmore) (N) 572
A basic formulary for general practice (GB Grant, DA Gregory and TD Van Zwaneberg) 421–422
A great and growing evil. *The medical consequences of alcohol abuse* (The Royal College of Physicians) 469
A handbook for medical teachers (D Newble and R Cannon) 470
A practical approach to asthma (R Pauwels and PD Snashall) 518
Affective disorders in the elderly (E Murphy) 228
Aids for the management of incontinence (B Ryan-Woolley) 326
AIDS. *The acquired immune deficiency syndrome* (VG Daniels) 470
Alcoholism: insight into the addictive mind (C Graymore) 421
America's health in the balance: choice or chance? (HH Hiatt) 517
An outline of psychotherapy for medical students and practitioners (H Maxwell) 325
Attempting suicide (K Hawton and J Catalan) 325
Behavioral counseling in medicine (ML Russell) 325
Building community: with people with mental handicaps, their families and friends (A Shearer) 183
Cancer pain (M Swerdlow and V Ventrifrida) 565
Cardiovascular care of the elderly (T Strasser) 565–566
Care of the child with diabetes (JD Baum and AL Kinmonth) 44
Caring for dying people of different faiths (J Neuberger) 184
Case presentations in clinical geriatric medicine (GS Rai, PJ Murphy and G Wright) 518
Child care through the centuries (J Cule and T Turner)
Child psychiatry. *A developmental approach* (P Graham) 227
Childhood asthma: diagnosis, treatment and management (T Milner) 422
Children with cancer. *A comprehensive guide for parents* (JM Bracken) 184
Class and health (RG Wilkinson) 278
Clinical medicine (PJ Kumar and ML Clark) 373
Clinical rheumatology (V Wright) 470
Continence and incontinence (PS Smith and LJ Smith) 325–326
Coronary heart disease (G Sandler) 326
Coronary heart disease: reducing the risk (Open University Department of Health and Social Welfare) 420

Dealing with drugs (A Dixon) 470
Dementia and mental illness in the old (E Murphy) 184
Diabetes mellitus (MB Davidson) 44
Disease data book (J Fry, G Sandler and D Brooks) 44
Employing staff (N Ellis) 373
Encounters between doctors and patients (JD Stoeckle) 373
Epidemiology and health policy (S Levine and A Lilienfeld) 278
Examination of the back (JK Paterson and L Burn) 88
Exploration in quality assessment and monitoring (A Donabedian) 184
Fighting heart disease (C Patel) 420
From birth to five (BR Butler and J Golding) 227
Geriatrics (A Martin and EC Gambrill) 136
Headache (R Peatfield) 88
Headache (WE Waters) 88
Health care information (DG Knox) 372
Health care UK — 1986 (A Harrison and J Grettton) 87–88
Health promotion in North America (C Robins) 372
Healthy public policy: a role for the HEA (King's Fund Institute) 421
Healthy respect. *Ethics in health care* (RS Downie and KC Calman) 227–228
IC — process — PC. *International classification of process in primary care* (WONCA) 136
In a man's world (A Spencer and D Podmore) 276–277
In that case. *Medical ethics in everyday practice* (AV Campbell and R Higgs) 87–88
Infectious diseases (D Brooks and EM Dunbar) 136
Infertility: a guide for the anxious couple (M Anderson) 422
Intersectoral action for health (WHO) 326
Just a word, doctor (BJ Freedman) 566
Let's drink to your health! (I Robertson and N Heather) 421
Liaison psychiatry. *Mental health problems in the general hospital* (J Gomez) 228
Making the break (A Richardson and J Ritchie) 183
Medical care and the general practitioner 1750–1850 (I Loudon) (N) 95
Medicine and the bible (B Palmer) 277
Morbidity figures from general practice (HJM Van Den Hoogen, FJA Huygen, JWG Schellekens, JM Straat and HGM Van Der Velden) 136
National health development networks in support of primary health care (WHO) 135–136
Neuromuscular diseases (J Bethlem and CE Knobbout) 422
Obstetrics and gynaecology in general practice (J Eddy and J Owen) 517–518
Occasional papers: *see* Royal College of General Practitioners
Oxford textbook of medicine (DJ Wetherall, JGG Legingham and DA Warrell) 326
Partners in care (PG Livesey) 277–278
Partnership or prejudice (J Walton and G McLachlan) 373
People with mental handicap (J Hattersley, GP Hoskins, D Morrow and M Myers) 566
Philosophical medical ethics (R Gillon) 228
Post-viral fatigue syndrome (AM Ramsay) 565
Practice psychiatry of old age (J Wattis and M Church) 277
Prescribing in pregnancy (PC Rubin) 422
Primary care of the elderly: a practical approach (J Williamson, RG Smith and LE Burley) 469
Promoting health through participation (A Richardson and C Bray) 372
Psychiatry in medical practice (D Goldberg, S Benjamin and F Creed) 277
Re-assessing community care (N Malin) 183–184

Reports from general practice: see Royal College of General Practitioners

Rights and wrongs in medicine (P Byrne) 228

Safe space (A Fry) 565

Screening for risk of coronary heart disease (M Oliver,

M Ashley-Miller and D Wood) 276

Selective antibiotic use in respiratory illness (MT Everett) 43-44

Skin disease in old age (R Marks) 469-470

Strategic planning in the health sector (T Rathwell) 566

Stroke. A self-help manual for stroke sufferers and their relatives (RM Youngson) 469

Strokes (C Warlow) 276

Textbook of medical record linkage (JA Baldwin, ED

Acheson and WJ Graham) 518

The emperor's new clothes (J Allsop and A May) 135

The geography of health services in Britain (R Hayes)

278

The man behind the syndrome (P Beighton and G

Beighton) 228

The use of computers in general practice (J Preece) 43

Ulcer and non-ulcer dyspepsia (M Lancaster-Smith) 276

Understanding senile dementia (AF Jorm) 518

War is good for babies and other young children (D

Dwork) 226

When a doctor hates a patient and other chapters in a

young physician's life (RE Peschel and ER Peschel)

420

Where to be born (R Campbell and A Macfarlane) 517

William Withering and the foxglove (RD Mann) 87

Women, drinking and pregnancy (M Plant) 421

Breast cancer: screening of (C) 510

British Geriatric Society: honour for K Thompson (N) 93

Brucellosis: multiple symptoms with, differentiation from

Coxsackie B (C) 318-319

Burn-out: general practitioners and, TC O'Dowd (E)

290-291, (C) 513

C

Cancer:

Bladder, symptoms of (C) 367

Breast: see Breast cancer

Cervical: see Cervical cancer screening

Careers:

Emotional needs of (N) 522

Support groups for (C) 368

Census data:

Examples of use in general practice, C Foy *et al*

451-454

How to use in general practice, A Hutchinson *et al*

448-450

Cervical cancer screening:

Call and recall system, LL Ridsdale 257-259

Health authority video (N) 378

National Federation of Women's Institutes (N) 137

Study of overdue women, P Meadows 500-503

Survey of population coverage, A Coulter and A

Baldwin 441-443

Childbirth: see Labour

Children:

Antibiotic prescribing, parental expectations (C) 42

Developmental screening (C) 42

Dying at home, R Burne (E) 291, (C) 461-462

Respiratory illness, longitudinal study, C Van Weel *et al*

404-408

Sexual abuse of (C) 416

Variation in consulting rates, JK Duncan *et al* 251-254

Visits to, is admission always required? (C) 41

Chlamydia trachomatis:

Methods of detecting in practice, HJ Longhurst *et al*

255-256, (C) 417

Neonatal conjunctivitis caused by (C) 82, (C) 274

Chvostek symptoms owing to dietary fibre (C) 40

Cigarette smoking: see Smoking

Clinical psychology: see Psychology

Coffee: effect on risk of coronary heart disease, MC Stone

(E) 146-147

Community care: service needs for the elderly, KA Luker

and ES Perkins 248-250

Community medicine: cooperation with primary care, PJ

Heath (E) 338-339

Community nursing: alternatives to Cumberlege proposals,

EI Williams and AD Wilson, 507-509

Complaints:

Against general practitioners: failure to visit (C) 323

Procedure in Britain (C) 222

Computers:

Faculty computer (N) 383, (C) 425

Free computer scheme (N) 330

General practice, future trends, F Difford (E) 434-435

Problems of coordination (C) 130-131

RCGP/GMSC guidelines for data extraction (N) 425

Updating (C) 180

Confidentiality: disclosure of medical information (C)

560-561

Conjunctivitis: neonatal, caused by chlamydia (C) 82, (C)

274

Consultation length: see Workload

Consultation rates: see Workload

Consulting patterns: comparison of doctors' perceptions and

patients' behaviour, E Martin and S Goodwin 23-24

Continuing education:

Extended residential courses, DC MacInnes (E) 1-2

Higher professional training course (N) 335

Involvement of general practitioners (C) 83-84

William Pickles Lecture 1987, M McKendrick 292-295

Coronary heart disease:

Coffee and, MC Stone (E) 146-147

Origin of modern epidemic, AU MacKinnon 174-176

Prevention of (C) 132

Register of rehabilitation facilities (C) 562

Screening clinics, other problems raised (C) 178

Workshop (N) 45

Course organizers: in general practice (C) 86

Coxsackie B virus: post-viral syndrome and, prospective

study, BD Calder *et al* 11-14, (C) 223, (C) 318-319

D

Deafness: see Hearing loss

Depression in general practice, DP Gray (E) 436

Diabetes:

Care of, PJ Burrows *et al* 65-69

Care of in practice, conference (N) 573

Chiropody services for diabetics (C) 275

General practitioner care of, J Nabarro (E) 389, (C) 562

Diagnosis:

Family practice methods (C) 84

Scoring system for urinary tract infection, FF Dobbs

and DM Fleming 100-104, (C) 273

Diet: fibre, sensory Chvostek symptoms from (C) 40

Doctors: dress and (N) 284, (C) 329

Drug abusers:

Rehabilitation unit, HIV infection in (C) 131

Survey of in Bristol, J Parker and M Gay 260-263

Toxicological screening for management of, CA

Skidmore *et al* 397-399

Drug formularies: introducing to general practice, PHG

Beardon *et al* 305-307

Drug prescribing: see Prescribing

Drug surveillance:

Post-marketing surveillance of enalapril in hypertension,

WD Cooper *et al* 346-349, (C) 514

Post-marketing surveillance of new drugs, EG Buckley

(E) 337-338, (C) 514

Drugs: information about (C) 221

E

Eaerache: see Otagia

ECG monitoring: ambulatory, WJD McKinlay and PC

Barnes 395-396

Education, medical:

Assessment, KM Parry (E) 145-146

Assessment with objective structured clinical

examination, R Walker and B Walker 123-124, (C)

275

Diploma in Geriatric Medicine (C) 225

Objective structured clinical examination, DM Thomson

149-153

Postgraduate GP experience for hospital specialists (N)

288

RCGP role in, N Oswald (N) 521

Teaching of ethics, D Seedhouse (E) 388-389

Elderly:

Accommodation for (C) 133

Age Concern appeal on cold (N) 91

Care of (C) 133

Community rehabilitation unit (C) 177-178

Diploma in Geriatric Medicine (C) 225

Dispersed alarm system for, M McWhirter 244-247

Log diaries in MRGCP (C) 85

Minimum data set for care of, SJ Jachuck and JR

Mulcahy 207-209, (C) 321

MRGCP examination questions and (C) 418, (C) 562

Multidisciplinary care (C) 466

Nursing homes, regulation of (C) 84-85

Prevalence of atrial fibrillation, JD Hill *et al* 172-173

Preventive care of, DP Gray (E) 98

Remedies dispensed in residential homes, PB Weedle

et al 412-413

Screening at consultation, CB Freer 455-456

Service needs and provision at home, KA Luker and ES

Perkins 248-250

Service provision, rural-urban variations, ID Fordyce

and DJ Hunter 109-111

Electrocardiographic monitoring: see ECG

Emergency bed service: survey of in London, BG Evans

491-493

Epilepsy: audit and change over eight years in a practice,

MP Taylor 116-119

Erythema infectiosum: see Parvovirus infection

Ethics:

Committee, proposals received, FM Sullivan and JH

Barber 365-366, (C) 465

Confidentiality, survey by Northumberland LMC, A

Hutchinson (N) 478

Disclosure of medical information (C) 560-561

Informed consent, J Cule (E) 242-243

Medical, teaching of, D Seedhouse (E) 388-389

Pharmaceutical industry and, DW Wall 267-269, (C)

464-465

Ethnic differences: in expectations at consultation and

self-medication, SJ Gillam 205-206

Eye, red: survey of doctors, A Wilson 62-64

F

Falklands war: psychiatric sequelae among veterans, GH

Jones and JWT Lovett 34-35, (C) 182, (C) 321-322

Family practitioner services: distribution of and efficiency,

S Birch and A Maynard 537-539

Fibrillation, atrial: see Atrial fibrillation

Finland: general practitioner beds, R Jones 28-30, (C)

181-182

Formularies: see Drug formularies

G

Gardnerella vaginalis: clinical prediction, TC O'Dowd and

RR West 59-61

Gastroscopy service: open access, findings and referral

rate, AS Hungin 170-171

General health questionnaire:

Screening for psychiatric illness in general practice, D

Goldberg and K Bridges 15-18

Use in hidden psychiatric illness, AF Wright and AF

Perini 164-167

General practice: see also Primary health care

Academic, M Marinker (E) 385-387

Payment of doctors, JS McCormick (E) 2

Role of academic departments, RH Davis 196-198

UK, Australian's impression, M Kamien 36-38, (C) 222

General practitioner hospitals: Finland, R Jones 28-30,

(C) 181-182

General practitioners:

Burn-out and job stress, TC O'Dowd (E) 290-291,

(C) 513

Hobbies, canal boats (N) 523

Role models for behaviour (C) 85

Sex of, and women's health, S Nichols 540-543

Genitourinary problems: symptoms of bladder carcinoma

(C) 367

Geographical isolation: general practice in Outer Hebrides,

I McNamara (N) 480

Geriatrics: see Elderly

Good practice allowance: see Royal College of General

Practitioners

Gout: azapropazone versus indomethacin/allopurinol

treatment, RC Fraser *et al* 409-411, (C) 561

Green paper on primary health care: see Primary health

care

Gynaecomastia: puberty, treating (C) 178

H

Hay fever: treatments for, MF D'Souza *et al* 296-300

Headache: study in North America, report from the

Ambulatory Sentinel Practice Network 400-403

Health education:

Alcohol consumption in pregnancy, A McKnight and D

Merrett 73-76

Aspirin and Reye's syndrome, RW Hall 459-460

District health education departments (C) 275, (C) 419

Students and AIDS, JS Brown *et al* 457-458

Health promotion: sexual behaviour and, M Clarke

555-556

Health questionnaires (C) 513

Health services: see also Primary health care

Infectious diseases update: 99, 209, 310, 403, 487
 Influenza: prevention (N) 520
 Information booklets: for hypertensive patients, CJ Watkins *et al* 548–550
 Informed consent, J Cule (E) 242–243
 Inner cities: RCGP/RCP joint conference (N) 423, (C) 520
 Intrapartum care: *see* Labour
 Ireland: payment of doctors, JS McCormick (E) 2
 Israel: kibbutz doctor (N) 379

J

Job loss: *see* Unemployment
Journal of the Royal College of General Practitioners: Abstracts (E) 436

L

Labour:
 Comparison of GP and specialist units for low-risk labour, SW Lowe *et al* 484–487
 Comparison of hypnosis and conventional relaxation for labour, LR Brann and SA Guzvica 437–440
 Outcome of women booked at GP unit, T Garrett *et al* 488–490
 Leprosy: Sungai Buluh Leprosaria, student elective visit (N) 94
 Lifestyle: relationship with social class, A Coulter 533–536
 Lisa Sainsbury Foundation: emotional needs of carers of the dying (N) 522
 List size: *see* Workload
 Lists: personal versus shared, S Priestman (E) 147–148

M

Malaria:
 Advice to travellers, H Campbell 70–72, (C) 223
 Wellcome Tropical Institute exhibition (N) 233
 Management in practice: *see* Practice management
Mastermind: College member wins (N) 329
 Measles immunization:
 Anaphylactic shock (C) 41
 Parents' attitude to, M Morgan *et al* 25–27, (C) 182
 Medical Foundation for the Care of Victims of Torture (C) 369
 Medical records: *see* Records
 Mentally handicapped:
 Closure of hospitals for, D Livingstone (E) 97–98, (C) 321
 Medical needs of (C) 133
 MRCGP examination:
 Alternative to, for established principals (C) 371
 Candidates (N) 92
 Candidates passing (N) 424
 Elderly patients in log diaries (C) 85
 Examination questions 39, 315, 557
 Examination technique, J Heyes 316, (C) 418
 Postal course (C) 42
 Preparation course (N) 334
 Reform of (C) 323, (C) 466, (C) 514
 Suggested new name (C) 275
 Musculoskeletal problems: *see* Orthopaedics
 Myalgic encephalomyelitis: *see* Post-viral syndrome
 Myocardial infarction: opiate administration in (C) 416–417

N

National Health Service: prescribing costs and, DA Gregory (E) 531–532
 Nuclear war: SCOPE report (N) 47
 Nurse practitioners:
 Cooperation with general practitioners (C) 181
 Working style and pattern of consultations, B Stilwell *et al* 154–157
 Nurses: district and health visitors, collaboration with general practitioners, J Bond *et al* 158–161
 Nurses, practice:
 Sheffield Conference (N) 526
 Social and occupational characteristics, S Greenfield *et al* 341–345, (C) 561
 Study days (N) 333
 Training for prevention (C) 221–222
 Nursing: community, study day (N) 188
 Nursing homes:
 Regulation of (C) 84–85
 Remedies dispensed in, PB Weedle *et al* 412–413

O

Obituary: JG Gurina (N) 474
 Objective structured clinical examination:
 Assessment of vocational trainees, R Walker and B Walker 123–124, (C) 275
 Design, validity and reliability, DM Thomson 149–153
 Old people: *see* Elderly
 Open-access gastroscopy service, findings and referral rate, AS Hungin 170–171
 Orthopaedics: use in general practice (C) 560
 Osteoporosis: *see* Bone and joint problems
 Otalgia: misdiagnosis as otitis media (C) 418–419, (C) 562
 Otitis media: antibiotic treatment of (C) 132, (C) 367, (C) 418–419, (C) 464, (C) 562
 Out-of-hours calls: *see* Workload

P

Paediatrics: *see* Children
 Paramedics: offshore, medical support for, JC Phillips 168–169
 Parvovirus infection: pruritus in, TA Jacks 210–211
 Patients:
 Access to records (C) 134
 Information for hypertensives, CJ Watkins *et al* 548–550
 Living without health, J Herman (E) 50
 Patients' Liaison Group meeting (N) 574
 Problem, diagnosis and management, J Cohen (E) 51
 Satisfaction, correction to paper by C Smith (C) 465–466
 Self-care, lay and professional interest in, MB Schulte and A Richardson 311–313
 Performance review:
 East Anglian general practice performance review unit (N) 384
 Experience of 'What sort of doctor' visit (N) 239
 Pharmaceutical industry:
 Ethics, DW Wall 267–269, (C) 464–465
 Promotion by, D Hilton 270, F Wells 271, (C) 371, (C) 419, (C) 465
 Physiotherapy: in the community, C Partridge (E) 194–195, (C) 368
 Politics: interviewing candidates for general election, PL Moore (N) 432
 Pollution: radiochemical, medical problems of, J Heyes (N) 525
 Postgraduate education: *see* Continuing education or Vocational training
 Post-marketing surveillance: *see* Drug surveillance
 Postnatal care: needs of mothers, S Smith (E) 2–3
 Post-viral syndrome:
 Cossackie B virus and, prospective study, BD Calder *et al* 11–14, (C) 223, (C) 318–319
 Review of, MI Archer 212–214, (C) 370–371, (C) 512
 Practice management:
 Age-sex registers (C) 560
 Annual reports, AS Urquhart (E) 148
 Executive partner, CJ Atkinson (E) 193–194
 Practice libraries (N) 281
 Practice receptionist programme (N) 574
 RCGP course (N) 143
 RCGP package (N) 189
 Training course (N) 429
 Practice nurses: *see* Nurses, practice
 Preconception clinics (C) 510
 Pregnancy: alcohol consumption in, A McKnight and D Merrett 73–76
 Prescribing:
 Costs, effect of drug formulary, PHG Beardon *et al* 305–307
 Costs of, A Jacob (E) 195
 Faculty projects (N) 287
 Health service costs and, DA Gregory (E) 531–532
 Parental expectations of antibiotic prescribing in children (C) 42
 Rational, assessment of, TD van Zwanenberg *et al* 308–310
 Terminal care, changes in, WD Rees 504–506
 Prevention:
 Breast cancer screening (C) 510
 Cervical cancer, call and recall system, LL Ridsdale 257–259, (C) 512
 Cervical cancer, population coverage, A Coulter and A Baldwin 441–443
 Coronary heart disease clinics (C) 132
 Elderly, consultation-based, CB Freer 455–456
 Integration of general practice and community medicine, DH Stone 218–220, (C) 368
 Problems raised by patients at clinics (C) 178
 Study of women overdue for cervical smear, P Meadows 500–503
 Training practice nurses for (C) 221–222
 Primary care team:
 Collaboration between nurses and general practitioners, J Bond *et al* 158–161
 Physiotherapists, C Partridge (E) 194–195, (C) 368
 Practice nurses, S Greenfield *et al* 341–345, (C) 561
 Sheffield practice nurses forum (N) 526
 Terminal care and, D Aldridge 364, (C) 463–464
 Primary health care: *see also* Health services
 College response to government Green Paper (E) 99
 Cooperation with community medicine, PJ Heath (E) 338–339
 Costs of, experience in the USA, A Hutchinson (E) 241–242
 Experimentation, M Marinker 125–128
 General practice and community medicine in prevention, DH Stone 218–220, (C) 368
 GPs' opinions on government proposals (C) 511
 Health care units as alternative to Cumberlege proposals, EI Williams and AD Wilson 507–509
 Manpower planning, E Martin (E) 530–531
 Scheme for single homeless, PV Powell 444–447
 Social Services Committee report (N) 187
 Sri Lanka, hospital or general practice, M Varnam 31–33
 Prison medicine (N) 377–378, (C) 425
 Problem patients: diagnosis and management, J Cohen (E) 51
 Pruritus: parvovirus infection and, TA Jacks 210–211
 Psychiatric illness:
 Falklands war veterans, GH Jones and JWT Lovett 34–35, (C) 182, (C) 321–322
 GP versus screening questionnaire, D Goldberg and K Bridges 15–18
 Hidden, use of general health questionnaire, AF Wright and AF Perini 164–167
 Psychiatry:
 Asperger's syndrome, case report, CM Goodman 414–415

Child, departments of, communication with GPs, R Kentish *et al* 162–163
 Psychology:
 Clinical, evaluation of treatment in primary care, C Treпка and T Griffiths 215–217
 Clinical, links with self-help for anxiety, CG Long and V Bourne 199–201
 Clinical, patients' preference on venue for appointments (C) 130
 Risk factors for mortality after bereavement, A Bowling and J Charlton 551–554
 Psychosocial illness: survey of management, CR Whitehouse 112–115

R

Receptionists, practice, *see* Ancillary staff
 Records:
 Patient's access (C) 134
 Summarizing practice records (C) 42
 Red eye: survey of doctors, A Wilson 62–64
 Redundancy: *see* Unemployment
 Referral rates: variation in, D Wilkin and AG Smith 350–353, (C) 462
 Rehabilitation: register of facilities for coronary patients (C) 562
 Rehabilitation unit: elderly (C) 177–178
 Research: quality of caring, James Mackenzie Lecture, JGR Howie 4–10
 Research methods: course (C) 514
 Research projects: faculty meeting (N) 240
 Respiratory illness: childhood, longitudinal study, C Van Weel *et al* 404–408
 Respiratory tract infection: upper, predisposing factors in patients over 12 years old, SP Bullimore 107–108, (C) 274
 Retirement:
 GPs relationship with College, K Thompson (N) 431, (C) 520
 Health and preparation for, J Harte (E) 483
 Reflections on, D Cannon (N) 382
 Rey's syndrome: aspirin and parents' knowledge, RW Hall 459–460
 Royal College of General Practitioners:
 AIDS, response to Social Services Committee (N) 90
 Annual general meeting (N) 567–571
 Annual symposium (N) 519, (N) 571
 Archives (N) 93, (C) 94, (N) 142, (N) 236, (N) 428
 Beds and Herts faculty secretary (N) 286
 Birmingham research unit weekly returns service (N) 575
 Board of Examiners (C) 86
 Building, history of (N) 572
 Chairman of Council, interview with (N) 140, report (N) 230–232 and 236, annual report (N) 568–571
 Chairman of Council resigns (N) 89
 Computing guidelines (N) 425
 Constitutional crisis (C) 323, (C) 466
 Council ballot procedure (N) 330
 Council elections (C) 42
 Council faculty representative, view of, R Walker (N) 477
 Council meeting report (N) 89, (N) 137, (N) 185, (N) 327, (N) 471
 Cumberlege report, response to (N) 138
 Diabetes conference (N) 573
 Faculty meeting on research and education, JA Grant (N) 430
 Faculty secretaries conference (N) 186
 Future of College, J Fry (N) 280, D Kalra (N) 525
 Guernsey branch for Wessex faculty (N) 187
 Healthcare, endorsement of (N) 279, (C) 371, (C) 465
 Improving communication (N) 335
 Inner cities conference with RCP (N) 423, (C) 520
 International affairs advisory group (C) 85–86
 James Mackenzie exhibition (N) 192
 James Mackenzie Lecture 1986, JGR Howie 4–10
 Jersey branch for Wessex faculty (N) 575
Journal: see that title
 Journalist's view of (N) 336
 Management appreciation programme (N) 143
Management in practice package (N) 189
Member's reference book (C) 42
 Membership Division Chairman (N) 141
 Membership examination: *see* MRCGP examination
 Membership for established principals (C) 371
 Midland faculty administrator (N) 479
 New Year's Honours: D Irvine, P Higgins, T Gardner (N) 93
 North west faculty patient liaison group (N) 238
 Occasional papers:
 35: *Preventive care of the elderly — a review of current developments*, DP Gray (E) 98
 36: *The presentation of depression: current approaches*, DP Gray (E) 436
 Organization and structure (C) 225
 Patients' Liaison Group meeting (N) 574
 Politics and (C) 323, (C) 466
 Report from general practice 25: *The front line of health service, College response to 'Primary health care: an agenda for discussion'* (E) 99
 Research fellows appointed: M Gallagher, S Iliffes, A Rashid (N) 423
 Research fellowships (N) 188
 Role in medical education, N Oswald (N) 521
 Role of faculty provost, PD Hooper (N) 527
 Royal College of Psychiatrists' joint meeting (N) 239
 Schering scholar study of trainers' workshops, P Ellis (N) 381 and 383
 Scottish Council (N) 472
 Severn faculty boundary change (N) 576
 South east Thames faculty and good practice allowance (C) 86
 Spring meeting (N) 229, (C) 329, report (N) 282
 Structure of, sub-faculties (N) 285

Stuart faculty fellow: J Donald (N) 576
 Stuart librarian (N) 46, practice visit (N) 141
 Tax relief on subscriptions (C) 419
 Trainee conference (N) 573
 William Pickles Lecture 1987, M McKendrick 292–295
 Working party on quality (N) 237
 Yorkshire faculty spring meeting (N) 336
 Rubella: immunization, general practice role in (C) 82, (C) 222

S

Screening: *see* Prevention
 Self-care:
 Lay and professional interest in, MB Schulte and A Richardson 311–313
 Pharmaceutical Society information campaign (N) 376
 Services: rural–urban variations in provision for the elderly, ID Fordyce and DJ Hunter 109–111
 Sexual abuse: children (C) 416
 Sexual behaviour: health and promotion initiative, M Clarke 555–556
 Sexual roles in partnerships: faculty meeting (N) 238
 Ship's medicine: (N) 475
 Single-handed practice: restrictions on trainees (C) 134
 Smoking:
 Patients' reasons for (C) 559
 Sale of cigarettes to children (C) 559
 Social class:
 Differential response to job loss (C) 129–130
 Relationship with lifestyle, A Coulter 533–537
 Societas Internationalis Medicinæ Generalis (SIMG) conference (N) 476
 Socioeconomic status: *see* Social class
 Sports medicine: Wimbledon tennis doctor (N) 283
 Sri Lanka: primary care in, hospital or general practice, M Varnam 31–33
 Sterilization: hysterectomy after (C) 272, (C) 369
 Students: AIDS, awareness of and attitudes to, JS Brown *et al* 457–458

T

Team, primary care: *see* Primary care team
 Telephone: use in managing out-of-hours calls, GN Marsh *et al* 301–304, (C) 462–463

Terminal care:
 Changes in prescribing in general practice, hospital and hospice, WD Rees 504–506
 Children at home, R Burne (E) 291, (C) 461–462
 Lisa Sainsbury Foundation (N) 522
 Team approach to, D Aldridge 364, (C) 463–464
 Theophylline: audit of serum concentrations, JC Howard 105–106, (C) 273–274, (C) 419, (C) 464
 Thyroidal problems: audit of management, study day (N) 524
 Tobacco use: *see* Smoking
 Torture:
 Medical Foundation for the Care of Victims (N) 281
 Victims, care of (C) 369
 Tranquillizers: *see* Benzodiazepines
 Travellers: malaria prophylaxis, H Campbell 70–72, (C) 223
 Tubal ligation: hysterectomy after (C) 272, (C) 369

U

Unemployment:
 Differential response to (C) 129–130
 Health of employees after redundancy, N Beale and S Nethercott 390–394
 United States of America: costs of health care, A Hutchinson (E) 241–242
 Universities: *see also* Academic general practice
 AUTGP annual scientific meeting (N) 427
 Edinburgh, department of general practice, new building (N) 375
 French professor's visit to Dundee (N) 375
 Urban practice: *see* Inner cities
 Urinary tract infection: scoring system for diagnosing, FF Dobbs and DM Fleming 100–104, (C) 273

V

Vaccination: *see* Immunization
 Vaginitis:
 Clinical prediction of *Gardnerella vaginalis*, TC O'Dowd and RR West 59–61
 Non-specific, clinical and laboratory studies MC Kelsey *et al* 56–58
 Vaginosis, bacterial, EG Buckley (E) 49–50

Video recording: consent by patients (C) 134, (C) 180–181, (C) 223–224, (C) 320
 Violence against doctors: Suzy Lamplugh Trust (N) 426–427
 Vocational training:
 Assessment with objective structured clinical examination, R Walker and B Walker 123–124, (C) 275
 Communication problems in trainers' workshops, P Ellis (N) 381 and 383
 Complaints against trainees (C) 222
 Course organizers (C) 86
 Faculty meeting (N) 240
 Faculty trainee sub-committee, A Green (N) 527
 Objective structured clinical examination, DM Thomson 149–153
 RCGP conference (N) 573
 Restrictions on trainees applying for single-handed practice (C) 134
 Trainees' research projects, conference (N) 576
 Voluntary organizations, M Payne (E) 339–340, (C) 512

W

War veterans: psychiatric illness, GH Jones and JWT Lovett 34–35, (C) 182, (C) 321–322
 Weight reduction: hypertension management (C) 83, (C) 179–180
 Women's health: preferences for sex of doctor, S Nichols 540–543
 Workload:
 Consultation length (C) 179
 Consultation rates and list sizes (C) 179
 Consultation rates, variation among children, JK Duncan *et al* 251–254
 In general practice (C) 40, (C) 224
 List size, M Roland (E) 481–482
 List size and consultation length, R Knight 19–22
 Manpower planning, E Martin (E) 530–531
 Patients' choice of length of consultation, L Lowenthal and E Bingham 498–499
 Patterns of, in Bromley, D Armstrong and GA Griffin 264–266, (C) 322, (C) 417
 Referral rates, variation in, D Wilkin and AG Smith 350–353, (C) 462, (C) 512–513
 Telephone advice in managing out-of-hours calls, GN Marsh *et al* 301–304, (C) 462–463

Author Index

A

Abraham P: Post-traumatic stress disorder (C) 321–322
 Alagaratnam TT: Treating puberty gynecomastia (C) 178
 Aldridge D: A team approach to terminal care: personal implications for general practitioners 364
 Ambulatory Sentinel Practice Network: A study of headache in North American primary care 400–403
 Anderson E and Anderson P: General practitioners and alternative medicine 52–55, (C) 461
 Anderson P: The DRAMS scheme in general practice (C) 511
 Anderson P: *see* Anderson E
 Anderson WV: Council and the Board of Examiners (C) 86
 Archer MI: The post-viral syndrome: a review 212–214
 Armitage P: *see* Bond J
 Armstrong D: Patterns of work in general practice (C) 417
 Armstrong D and Griffin GA: Patterns of work in general practice in the Bromley health district 264–266
 Ashton J: Future general practice (C) 181–182
 Askew MIF: *see* Jones RVH
 ASPN: *see* Ambulatory Sentinel Practice Network
 Atkinson CJ: The executive partner (E) 193–194

B

Bacon L: *Chlamydia trachomatis* infections (C) 417
 Bahrami J: Course organizers in general practice (C) 86
 Bailey P: Dressed for success (C) 329
 Bain J: *see* Jones R
 Baker JW: Crisis in College (C) 466
 Baker RH: Consultation rates and the primary care team (C) 179
 Baldwin A: *see* Coulter A
 Bangham AM: *see* Kelsey MC
 Bangham CE: Ethics and the pharmaceutical industry (C) 465
 Barber JH: *see* Sullivan FM
 Barnes PC: *see* McKinlay WJD
 Barton AG: *see* Bond J
 Bastin CJ: *see* Jones RVH
 Baxter P: *see* Jackson J
 Beacon S: Physiotherapy in the community (C) 368
 Beale N and Nethercott S: Differential response to job loss (C) 130

Beale N and Nethercott S: The health of industrial employees four years after compulsory redundancy 390–394
 Beardon PHG, Brown SV, Mowat DAE, Grant JA and McDavitt DG: Introducing a drug formulary to general practice — effects on practice prescribing costs 305–307
 Bell EJ: *see* Calder BD
 Berrow: Telephone advice in managing out-of-hours calls (C) 463
 Bethell HJN: Rehabilitation for coronary patients (C) 562
 Bingham E: *see* Lowenthal L
 Birch S and Maynard A: Regional distribution of family practitioner services: implications for National Health Service equity and efficiency 537–539
 Blakey R: *see* Crawford JR
 Boardman AP and Craig TKJ: Video recording in general practice (C) 180–181
 Bond J, Cartledge AM, Gregson BA, Barton AG, Philips PR, Armitage P, Brown AM and Reedy BLEC: Interprofessional collaboration in primary health care 158–161
 Booth R: *see* Finlay IG
 Boulos G: Failure to visit (C) 323
 Bourne V: *see* Long CG
 Bowling A and Charlton J: Risk factors for mortality after bereavement: a logistic regression analysis 551–554
 Boyd EMA: Post-tubal-sterilization syndrome (C) 272
 Bradley CP: Caring for AIDS — GPs must act now (C) 273
 Bradley NCA: Sale of cigarettes to children (C) 559
 Brann LR and Guzmica SA: Comparison of hypnosis with conventional relaxation for antenatal and intrapartum use: a feasibility study in general practice 437–440
 Brennan PJ: *see* Wallace PG
 Bridges K: *see* Goldberg D
 Bridges-Webb C: Who owns the patient's record? (C) 134
 Brogan C: Antibiotics in acute otitis media (C) 464
 Brown AM: *see* Bond J
 Brown D: *see* Cooper WD
 Brown DW: Serum theophylline concentration in general practice patients (C) 273–274
 Brown JS, Irwin WG, Steele K and Harland RW: Students' awareness of and attitudes to AIDS 457–458
 Brown SE: MRCGP examination (C) 466
 Brown SV: *see* Beardon PHG
 Browne D: Health promotion (C) 274–275
 Bruce JN: Organizing the faculty (N) 479
 Buckley EG: Bacterial vaginosis (E) 49–50

Buckley EG: Post-marketing surveillance of new drugs (E) 337–338
 Bullimore SP: Upper respiratory tract infection: predisposing factors and duration of symptoms in patients over 12 years of age 107–108
 Burne R: The dying child at home (E) 291
 Burrows PJ, Gray PJ, Kinmonth A-L, Payton DJ, Walpole GA, Walton RJ, Wilson D and Woodbine G: Who cares for the patient with diabetes? Presentation and follow-up in seven Southampton practices 65–69
 Calder BD, Warnock PJ, McCartney RA and Bell EJ: Cossackie B viruses and the post-viral syndrome: a prospective study in general practice 11–14
 Cameron J: Journalist's view of the College (N) 336
 Campbell H: Imported malaria in the UK: advice given by general practitioners to British residents travelling to malaria endemic areas 70–72
 Campbell M, Greig E, Ledingham E, McLeod E, McKenzie J and Youngs H: A first for Scotland? (N) 429
 Campion PD: *see* Heather N
 Campkin M: Crisis in the College? (C) 323
 Cannon D: Looking back (N) 382
 Carr N: Acute anal pain and a chicken bone, 314
 Cartledge AM: *see* Bond J
 Cartwright N: Azapropazone in the treatment of gout (C) 561
 Cashman D: Telephone advice in managing out-of-hours calls (C) 463
 Chambers EJ, Cornish J, Oakhill A and Curnick S: The dying child at home (C) 461–462
 Chambers JA: Opiate administration in acute myocardial infarction (C) 416–417
 Channing DM: *see* Marsh GN
 Channing N: The College and politics (C) 466
 Chapman R: Man at the helm (N) 286
 Chapman R: Spring meeting (C) 329
 Charlton J: *see* Bowling A
 Charlton JRH: *see* D'Souza MF
 Chinn S: *see* Watkins CJ
 Clarke M: Sex and health promotion: the need for a new primary care initiative 555–556

Clarke WL and Curtis HA: AIDS: not deficient but immune (C) 510-511
 Clayton S: *see* Payne M
 Clough L: Practice nurses study days (N) 333
 Clubb AS: Geriatrics and the MRCPG examination (C) 562
 Cohen J: Diagnosis and management of problem patients in general practice (E) 51
 Cohen J and Southgate J: Annual scientific meeting of AUTGP (N) 427
 Cohen MD and Silverberg DS: Weight reduction in the management of hypertension (C) 83
 Coleman NS: Telephone advice in managing out-of-hours calls (C) 463
 Collacott RA: Medical needs of the mentally handicapped (C) 133
 Colvin D: *see* Salkind MR
 Constantinidou M: *see* Longhurst HJ
 Coop JA: *see* Jones RVH
 Coope GA: *see* Coope JR
 Coope JR, Coope GA and Lawton S: Prevention of heart disease (C) 132
 Cooper WD, Sheldon D, Brown D, Kimber GR, Isitt VL and Currie WJC: Post-marketing surveillance of enalapril: experience in 11 710 hypertensive patients in general practice 346-349
 Cornish J: *see* Chambers EJ
 Cossar JH: *see* Walker E
 Coulter A: Lifestyles and social class: implications for primary care 533-536
 Coulter A and Baldwin A: Survey of population coverage in cervical cancer screening in the Oxford region 441-443
 Cox J: *see* Phillips W
 Craig TKJ: *see* Boardman AP
 Crawford JR, Blakey R and Gullion FE: Clinical psychology and primary care: patients' views on the venue for appointments (C) 130
 Croft P: Weight reduction in the management of hypertension (C) 180
 Crombie DL and Fleming DM: Variation in general practitioners' referral rates to consultants (C) 462
 Cule J: Informed consent (E) 242-243
 Curnick S: *see* Chambers EJ
 Currie WJC: *see* Cooper WD
 Curtis HA: *see* Clarke WL

D

Dale C: *see* Morgan M
 Dattani RT: When is a trainee fit to be let loose on patients? (C) 222
 Davies DM: *see* Garlick PR
 Davies DM: *see* Phillips W
 Davis RH: General practice and the unity of clinical medicine (Harvard Davis Lecture 1986) 196-198
 Davis RH: *see* Fraser RC
 Dawson LJ: *see* Toon PD
 Delvin DG: Post-tubal-sterilization syndrome (C) 369
 Dennis N: Inner cities conference (C) 520
 Dewar RD: *see* Walker E
 Difford F: Future trends in general practice computing (C) 434-436
 Dobbs FF and Fleming DM: A simple scoring system for evaluating symptoms, history and urine dipstick testing in diagnosis of urinary tract infection 100-104
 Doherty M: *see* Toon PD
 Doidge NH: Rubella immunization — what happens in our practice (C) 222-223
 Donald AG: Sponsorship and the medical profession (C) 371
 Doré CJ: *see* Salinsky JV
 Dowden JS: Visits to children: is admission always required? (C) 41
 Doyle PT: *see* Gardner BP
 Draper J: *see* Thomas H
 Drury M: SIMG: Prague 1987 (N) 476
 Drury M: *see* Greenfield S
 Drury M: *see* Stilwell B
 D'Souza MF, Tooley M and Charlton JRH: Hay fever treatments — which should be tried first? 296-300
 Duncan JK, Taylor RJ and Fordyce ID: Factors associated with variation in the consultation rates of children aged under five years 251-254

E

Elder A: *see* Longhurst HJ
 Elliott K: *see* Toon PD
 Elliott-Binns C: Retired College members (C) 520
 Ellis P: Study of trainers' workshops (N) 381 and 383
 Ellis P and Kelly M: Training practice nurses for prevention (C) 221-222
 Evans BG: The emergency bed service — a barometer of London's hospital service 491-493

F

Farrell PJS: *see* Jones RVH
 Fennell J: Voluntary organizations: an underused asset (C) 512
 Field S: *see* Thomas H
 Fields R: Reasons for smoking (C) 559
 Finlay IG and Booth R: Can general practitioners teach other general practitioners? (C) 83-84
 Finlay S: Post-viral syndrome (C) 370
 Fleming DM: Consultation length (C) 179
 Fleming DM: Diagnosing urinary tract infection (C) 273
 Fleming DM: *see* Crombie DL
 Fleming DM: *see* Dobbs FF
 Flower N: *see* Longhurst HJ

Fordyce ID and Hunter DJ: Rural-urban variations in service provision for elderly people 109-111
 Fordyce ID: *see* Duncan JK
 Fowler G: *see* Gray JAM
 Foy C, Hutchinson A and Smyth J: Providing census data for general practice. 2. Usefulness 451-454
 Foy C: *see* Hutchinson A
 Frank AJM: Medical Foundation for the Care of Victims of Torture (C) 369
 Fraser RC, Davis RH and Walker FS: *see* Comparative trial of azapropazone and indomethacin plus allopurinol in acute gout and hyperuricaemia 409-411
 Freeling P: *see* Tylee A
 Freeman GK: Personal versus shared lists (C) 319-320
 Freer CB: Anticipatory care of the elderly (C) 321
 Freer CB: Consultation-based screening of the elderly in general practice: a pilot study 455-456
 Fry J: At the crossroads of time (N) 280
 Fullard E: *see* Gray JAM
 Fuller IC: Is your loo door really necessary? (C) 275
 Furst A: Kibbutz doctor (N) 379

G

Gadsby R: Telephone advice in managing out-of-hours calls (C) 462
 Gallagher M: HIV infection in a rehabilitation unit (C) 131
 Gardner BP and Doyle PT: Symptoms of bladder carcinoma (C) 367
 Garlick PR and Davies DM: Summarizing practice records (C) 42
 Garrett T, House W and Lowe SW: Outcome of women booked into an isolated general practice maternity unit over eight years 488-490
 Garrett T: *see* Lowe SW
 Garvie DG: Tax relief on subscriptions (C) 419
 Gay M: *see* Parker J
 Gazzard B and Hawkins D: AIDS, HIV and general practice (C) 511
 Gibbons B: Integration of community medicine and primary care (C) 368
 Gillam SJ: Sociocultural differences in patients' expectations at consultations for upper respiratory tract infection 205-206
 Goldberg D and Bridges K: Screening for psychiatric illness in general practice: the general practitioner versus the screening questionnaire 15-18
 Golding AMB: The health needs of homeless families (E) 433-434
 Goodman CM: Asperger's syndrome: a case report 414-415
 Goodwin S: *see* Martin E
 Graffy J: 'Ms Piggy' — part II (N) 574
 Grafton A: Attendance allowance (C) 562
 Graham HJ: MRCPG candidates and the elderly (C) 85
 Graham J: *see* Tait I
 Grant GB: *see* Van Zwanenberg TD
 Grant JA: Gleneagles '87 — an educational initiative proving its worth (N) 430-432
 Grant JA: *see* Beardon PHG
 Gray DP: Chairman's annual report (N) 568-571
 Gray DP: Depression in general practice (E) 436
 Gray DP: International affairs advisory group (C) 85-86
 Gray DP: Preventive care of the elderly (E) 98
 Gray DP: The Chairman of Council's report (N) 230-232 and 236
 Gray JAM, O'Dwyer A, Fullard E and Fowler G: Rent-audit (C) 177
 Gray PJ: *see* Burrows PJ
 Gray R: Good practice allowance (C) 86
 Green A: The north of England faculty's trainee sub-committee (N) 527
 Green AD: Neonatal conjunctivitis (C) 274
 Greenfield S, Stilwell B and Drury M: Practice nurses: social and occupational characteristics 341-345
 Greenfield S: *see* Stilwell B
 Gregory DA: Health service costs and the general practitioner's role in relation to prescribing (E) 531-532
 Gregory DA: *see* Van Zwanenberg TD
 Gregson BA: *see* Bond J
 Greig E: *see* Campbell M
 Griffin GA: *see* Armstrong D
 Griffiths T: *see* Trepka C
 Grimshaw J: *see* Tait I
 Gude R: Membership for established principals (C) 371
 Gullion FE: *see* Crawford JR
 Guzvica SA: *see* Brann LR

H

Haines AP: *see* Wallace PG
 Hall D: Otagia in general practice (C) 562
 Hall RW: Aspirin and Reye's syndrome — do parents know? 459-460
 Hammond M: Patient libraries (N) 281
 Hammond M: Winter's tale (N) 141
 Harding J: Study of discharge communications from hospital doctors to an inner London general practice 494-495
 Hare MJ: *see* Thomas H
 Harland RW: *see* Brown JS
 Harley S: Orthopaedic medicine (C) 560
 Harris CM: Variation in general practitioners' referral rates to consultants (C) 512-513
 Hart A: Computers in practice — whither goest we? (C) 130-131
 Hart JT: Dr Jordi Gol i Gurina (N) 474
 Harte J: Health and preparation for retirement (E) 483
 Haslett S and Wooton G: Practice nurses (C) 561
 Hawkins D: *see* Gazzard B

Hay K: Weight reduction in the management of hypertension (C) 179-180
 Hayden J: North west England's patient liaison group (N) 238
 Hayden J: Practice computers (N) 383, (C) 425
 Heath PJ: Primary health care and community medicine: a new approach (E) 338-339
 Heather N, Campion PD, Neville RG and Maccabe D: Evaluation of a controlled drinking minimal intervention for problem drinkers in general practice (the DRAMS scheme) 358-363
 Henry DJ: Continuing audit of preventive care using a computer (C) 272-273
 Herman J: Living without health — a challenge to patient and doctor (E) 50
 Heyes J: Irish sea meeting (N) 525
 Heyes J: Straight from the horse's mouth 316-317
 Hill JD, Mottram EM and Killeen PD: Study of the prevalence of atrial fibrillation in general practice patients over 65 years of age 172-173
 Hill P: Feeling and focus in the faculty (N) 285
 Hilton D: Promotion by the drug companies — should we accept their bribes? 270
 Hochuli V: Health promotion (C) 419
 Holden JD: Ethics and the pharmaceutical industry (C) 464-465
 Hood WJM: *see* Phillips W
 Hooper P: GP experience for hospital doctors (N) 288
 Hooper PD: The role of the provost (N) 527
 Horne RA: *see* Marsh GN
 House W: *see* Garrett T
 House W: *see* Lowe SW
 Howard JC: Audit of serum theophylline concentrations in patients from general practice 105-106
 Howie JGR: Quality of caring — landscapes and curtains (James Mackenzie Lecture 1986) 4-10
 Hull FM: *see* Stilwell B
 Hull R: AIDS, HIV and general practice (C) 418
 Hungin AS: Use of an open-access gastroscopy service by a general practice: findings and subsequent specialist referral rate 170-171
 Hunter DJ: *see* Fordyce ID
 Hunter GM: Fourteenth century skeletons (N) 520
 Hurwood D: Trainees' social evening (N) 429
 Hutchinson A: College and LMC — working together in Northumberland (N) 478
 Hutchinson A: Cost containment at any price — experience in the USA (E) 241-242
 Hutchinson A, Foy C and Smyth J: Providing census data for general practice. 1. Feasibility 448-450
 Hutchinson A: *see* Foy C

I

Ingamells CR: Preconception clinics (C) 510
 Irwin WG: *see* Brown JS
 Isitt VL: *see* Cooper WD

J

Jachuck SJ and Mulcahy JR: Minimum data set necessary to promote the care of the elderly in general practice 207-209
 Jacks TA: Pruritus in parvovirus infection 210-211
 Jackson J and Baxter P: Thyroid study in the Highlands (N) 524
 Jacob A: What is the cost of a prescription? (E) 195
 Jarman B: Workload in general practice (C) 224
 Jarvie DR: *see* Skidmore CA
 Jarvie N: Scottish Council RCGP (N) 472
 Jarvis P: College elections (C) 42
 Jarvis PN: Voluntary organizations: an underused asset (C) 512
 Jary CA: *see* Phillips W
 Jenkins P: *see* Kentish R
 Jones GH and Lovett JWT: Delayed psychiatric sequelae among Falklands war veterans 34-35
 Jones K and Walker R: Health questionnaire (C) 513
 Jones KP: Restrictions on trainees applying for single-handed vacancies 134
 Jones NS: *see* Shaw J
 Jones R: General practitioner beds in Finland — lessons for the UK? 28-30
 Jones R and Bain J: Treatment of otitis media (C) 132
 Jones RVH, Lawrey KD, Wickins MC, Farrell PJS, Askew MF, Bastin CJ and Coop JA: Accommodation for the elderly (C) 133

K

Kalra D: Wither the College? (N) 525
 Kamien M: An Australian's impression of general practice in the United Kingdom 36-38
 Kapur DK: MRCPG examination (C) 42
 Keighley BD: A team approach to terminal care (C) 463-464
 Kelly M: *see* Ellis P
 Kelsey MC, Mann GK, Bangham AM and Milnthorpe J: Non-specific (anaerobic) vaginitis: relevance of clinical and laboratory studies in a practice population 56-58
 Kentish R, Jenkins P and Lask B: Study of written communication between general practitioners and departments of child psychiatry 162-163
 Killeen PD: *see* Hill JD
 Kimber GR: *see* Cooper WD
 Kinmonth A-L: *see* Burrows PJ
 Kinnersley PR: Healthcare and the College (C) 371
 Knibbs S: Chiropody services for diabetics (C) 275
 Knight R: The importance of list size and consultation length as factors in general practice 19-22

L

- Lakhani AD: see Morgan M
 Lask B: see Kentish R
 Lawrey KD: see Jones RVH
 Lawton S: see Coope JR
 Ledingham E: see Campbell M
 Levene LS: How general practitioners can help carers' support groups (C) 368
 Littman GA: GP registration among homeless people (C) 320
 Livingstone D: Hospitals for the mentally handicapped — run down or reform? (E) 97–98
 Long CG and Bourne V: Linking professional and self-help resources for anxiety management: a community project 199–200
 Longhurst HJ, Flower N, Thomas BJ, Munday PE, Elder A, Constantinidou M, Wilton J and Taylor-Robinson D: A simple method for the detection of *Chlamydia trachomatis* infections in general practice 255–256
 Lovett JWT: see Jones GH
 Lowe SW, House W and Garrett T: Comparison of outcome of low-risk labour in an isolated general practice maternity unit and a specialist maternity hospital 484–487
 Lowe SW: see Garrett T
 Lowenthal L and Bingham E: Length of consultation: how well do patients choose? 498–499
 Luker KA and Perkins ES: The elderly at home: service needs and provision 248–250

M

- Maccabe D: see Heather N
 McCallum N: A community rehabilitation unit for the elderly (C) 177–178
 McCartney RA: see Calder BD
 McCormick JS: Money and the nature of practice (E) 2
 McCormick JS: see Skrabanek J
 McDermott DG: see Beardon PHG
 MacDonald JD: Sabbatical leave (C) 513
 McGhee MF: Research methods course (C) 514
 MacInnes DC: Extended residential courses (E) 1–2
 Mackay HAF: Video recording in general practice (C) 181
 McKeith D: Parents' attitudes to measles immunization (C) 182
 McKendrick M: The professionals (William Pickles Lecture 1987) 292–295
 McKenzie J: see Campbell M
 McKinlay WJD: Personal versus shared lists (C) 319
 McKinlay WJD and Barnes P: Ambulatory electrocardiographic monitoring in a market town health centre 395–396
 MacKinnon AU: The origin of the modern epidemic of coronary artery disease in England 174–176
 MacKinnon M: Sheffield practice nurses forum (N) 526
 McKnight A and Merrett D: Alcohol consumption in pregnancy — a health education problem 73–76
 McLeod E: see Campbell M
 McNamara I: Isolated general practice (N) 480
 McWhirter M: A dispersed alarm system for the elderly and its relevance to local general practitioners 244–247
 Mann GK: see Kelsey MC
 Mann RD: see Wood SM
 Marinker M: Experimentation: the next step 125–128
 Marinker M: Journey to the interior: the search for academic general practice (E) 385–387
 Marks J: Sensory Chvostek symptoms, apparently owing to dietary fibre (C) 40–41
 Marsh GN, Horne RA and Channing DM: A study of telephone advice in managing out-of-hours calls 301–304
 Martin E: Inner cities conference (N) 423
 Martin E: Joint research meeting (N) 240
 Martin E: Medical foundation for the care of victims of torture (N) 281
 Martin E: Medical manpower planning: factors influencing workload in general practice (E) 530–531
 Martin E: Prison medicine (N) 377–378
 Martin E and Goodwin S: Consulting patterns: comparison between doctors' perceptions and patients' behaviour 23–24
 Martin J: see Watkins CJ
 Martin RWY: Cocksackie B viruses and the post-viral syndrome (C) 223
 Maughan H: see Tylee A
 Maynard A: see Birch S
 Meadows P: Study of the women overdue for a smear test in a general practice cervical screening programme 500–503
 Membrey T: What sort of doctor? (N) 239
 Merrett D: see McKnight A
 Miller AJ: Serum theophylline concentrations in general practice patients (C) 464
 Miller PI: see Rich M
 Milnthorpe J: see Kelsey MC
 Moore PL: Meeting the candidates (N) 432
 Morgan M, Lakhani AD, Morris RW, Dale C and Vaile MSB: Parents' attitudes to measles immunization 25–27
 Morris RW: see Morgan M
 Morrison JM: Nurse practitioners (C) 181
 Mottram EM: see Hill JD
 Mowat DAE: see Beardon PHG
 Mulcahy JR: see Jachuck SJ
 Munday PE: see Longhurst HJ
 Murdoch JC: Hospitals for the mentally handicapped (C) 321
 Murdoch JC: Post-viral syndrome (C) 512
 Murray TS: Projects and research (N) 576

N

- Nabarro J: Diabetes and the general practitioner (E) 389
 Nethercott S: see Beale N
 Nethercott S: see Beale N
 Neville RG: Notifying general practitioners about deaths in hospital: an audit 496–497
 Neville RG: see Heather N
 Nichols S: Women's preferences for sex of doctor: a postal survey 540–543
 Nigam R: Advertising in general practice (C) 42
 Nimmo TW: MRCGP examination (C) 275

O

- Oakhill A: see Chambers EJ
 O'Brien D: Serum theophylline concentration in general practice patients (C) 419
 O'Brien JA: A case of neonatal conjunctivitis caused by chlamydia? (C) 82
 O'Dowd TC: To burn out or to rust out in general practice (E) 290–291
 O'Dowd TC and West RR: Clinical prediction of *Gardnerella vaginalis* in general practice 59–61
 O'Dwyer A: see Gray JAM
 Ormer R: Falklands war veterans in general practice (C) 182
 Osborne J, Parker M, Rhodes M, Peter L, Peter B and Robinson C: Employing a medical student to audit the practice (C) 272
 Oswald N: Priorities in medical education (N) 521

P

- Papacosta AO: see Watkins CJ
 Parish PA: see Weedle PB
 Parker J and Gay M: Problem drug users known to Bristol general practitioners 260–263
 Parker M: see Osborne J
 Parry KM: The measurement of practice (E) 145–146
 Partridge C: Physiotherapy in the community (E) 194–195
 Payne M and Clayton S: Voluntary organizations: an underused asset (E) 339–340
 Paynton DJ: Variation in general practitioners' referral rates to consultants (C) 513
 Payton DJ: see Burrows PJ
 Pearson DA: The College and politics (C) 323
 Peel M: Post-viral syndrome (C) 370–371
 Perini AF: see Wright AF
 Perkins ES: see Luker KA
 Perkins P: Video recording in general practice (C) 223–224
 Peter B: see Osborne J
 Peter L: see Osborne J
 Phillips PR: see Bond J
 Phillips JC: Medical support by a team of doctors to offshore paramedics 168–169
 Phillips W, Hood WJM, Jary CA and Cox J: Workload in general practice (C) 40
 Playfair D: see Tait I
 Pollock EE and Thompson AT: Cervical screening in general practice (C) 512
 Poston JW: see Weedle PB
 Powell PV: A 'house doctor' scheme for primary health care for the single homeless in Edinburgh 444–447
 Price EM, Wallace P and Wilton J: Rubella vaccination — what happens in practice (C) 82–83
 Price J: Otitis media or externa? (C) 418–419
 Priestman S: Personal versus shared lists: a continuing debate (E) 147–148
 Pringle M: What sort of College do we want? (N) 237

R

- Reedy BLEC: see Bond J
 Rees WD: Changes in prescribing for terminal care patients in general practice, hospital and hospice over a five-year period 504–506
 Reid D: see Walker E
 Reilly DT and Taylor MA: General practitioners and alternative medicine (C) 369
 Reith W and Taylor MW: The objective structured clinical examination (C) 275
 Rhodes M: see Osborne J
 Rich M and Miller PI: An ethical committee for general practice (C) 465
 Richards C: The complaints system in British general practice (C) 222
 Richardson A: see Schulte MB
 Richardson PH: see Vincent CA
 Richmond DW: Paediatric developmental screening (C) 42
 Ridsdale LL: Cervical screening in general practice: call and recall 257–259
 Roberts GD: Video recording in general practice (C) 134
 Roberts V: Diabetes and the general practitioner (C) 562
 Robertson JR: see Skidmore CA
 Robinson C: see Osborne J
 Roland M: Is there a case for smaller lists? (E) 481–482
 Rose AJ: Post-marketing surveillance of enalapril (C) 514
 Rothery SP: Predisposing factors to infective disease (C) 274
 Rutledge P: Workload in general practice (C) 40

S

- Salinsky JV and Doré CJ: Characteristics of long term benzodiazepine users in general practice 202–204
 Salkind MR, Southgate LJ, Toon PD and Colvin D: Video recording in general practice (C) 224
 Sapper H: Management in general practice (N) 479
 Sapper H: Sexual roles in partnerships (N) 238
 Sapsford D: Practice staff (C) 323
 Schulte MB and Richardson A: A survey of lay and professional interest in self-care 311–313
 Scott RTA: Attitudes towards patients infected with HIV (E) 529–530
 Seedhouse D: The teaching of medical ethics (E) 388–389
 Seiler ER: Course organizers in general practice (C) 86
 Seiler ER: Reform of the MRCGP (C) 323
 Sharvill NJ: Disclosure of medical information (C) 560–561
 Shaw J and Jones NS: Drug information and the general practitioner (C) 221
 Shaw NJ: Antibiotic prescribing in young children: parental expectations (C) 42
 Shaw R: Role models: influence and change (C) 85
 Sheldon D: see Cooper WD
 Silverberg DS: see Cohen MD
 Simpson D: see Skidmore CA
 Skidmore CA, Robertson JR, Simpson D and Jarvie DR: Toxicological screening in heroin users: implications for management of drug misuse 397–399
 Skrabanek P and McCormick JS: General practitioners and alternative medicine (C) 224–225
 Smith AG: see Wilkin D
 Smith C: Patients' opinions on the services provided by a general practice (C) 465–466
 Smith S: Postnatal care — who cares? (E) 2–3
 Smits AJA: see Van Weel C
 Smyth J: see Foy C
 Smyth J: see Hutchinson A
 Southgate L: see Cohen J
 Southgate LJ: see Salkind MR
 Steel R: Working relationships (N) 239
 Steele K: see Brown JS
 Stilwell B, Greenfield S, Drury M and Hull FM: A nurse practitioner in general practice: working style and pattern of consultations 154–157
 Stilwell B: see Greenfield S
 Stone DH: Primary care, community medicine and prevention: a convergence of needs 218–220
 Stone MC: Coffee and coronary heart disease (E) 146–147
 Stuart D: The East Anglian MRCGP preparation course (N) 334
 Sullivan FM and Barber JH: An ethical committee for general practice in the West of Scotland: proposals received in the first year 365–366
 Swayne J: General practitioners and alternative medicine (C) 369–370

T

- Tait I, Graham J, Grimshaw J, Takhar A, Playfair C and Turner E: MRCGP examination (C) 514
 Takhar A: see Tait I
 Taylor MA: see Reilly DT
 Taylor MP: Epilepsy in a Doncaster practice: audit and change over eight years 116–119
 Taylor MW: see Reith W
 Taylor RC: Differential response to job loss (C) 129–130
 Taylor RJ: see Duncan JK
 Taylor-Robinson D: see Longhurst HJ
 Thomas BJ: see Longhurst HJ
 Thomas H, Draper J, Field S and Hare MJ: Evaluation of an integrated community antenatal clinic 544–547
 Thomas K: see Toon PD
 Thomas M: The age-sex register in general practice (C) 560
 Thomas P: Treatment of otitis media (C) 132
 Thompson AT: see Pollock EE
 Thompson K: The Diploma in Geriatric Medicine (C) 225
 Thompson K: The retired College member and his faculty (N) 431
 Thompson MK: Care of the elderly (C) 133
 Thompson MK: Geriatrics and the MRCGP examination (C) 418
 Thompson MK: Multidisciplinary care of the elderly (C) 406
 Thomson DM: The objective structured clinical examination for general practice: design, validity and reliability 149–153
 Thornton AS: Diagnosing urinary tract infection 273
 Thorpe GW: Use of hospital based investigations (E) 482–483
 Thurston A: Anaphylactic shock reaction to measles vaccine (C) 41
 Tomblinson PMJ: MRCGP modified essay question (C) 419
 Tooley M: see D'Souza MF
 Toon PD, Dawson LJ and Elliott K: Unexpected problems raised in prevention clinics (C) 178
 Toon PD, Thomas K and Doherty M: Audit of work at a medical centre for the homeless over one year 120–122
 Toon PD: see Salkind MR
 Treppa C and Griffiths T: Evaluation of psychological treatment in primary care 215–217
 Turner E: see Tait I
 Tylee A, Maughan H and Freeling P: Video recording in general practice (C) 320

U

- Urquhart AS: Practice annual reports (E) 148

V

- Vaile MSB: *see* Morgan M
 Van Buchem FL: Antibiotics for otitis media (C) 367
 Van den Bosch WJHM: *see* Van Weel C
 Van den Hoogen HJM: *see* Van Weel C
 Van Weel C, Van den Bosch WJHM, Van den Hoogen HJM and Smits AJA: Development of respiratory illness in childhood — a longitudinal study in general practice 404–408
 Van Zwanenberg T: *see* Waterston T
 Van Zwanenberg TD, Grant GB and Gregory DA: Can rational prescribing be assessed? 308–310
 Varnam M: The College and its Council (C) 225
 Varnam M: Practising prevention (N) 571
 Varnam M: Primary medical care in Sri Lanka: hospital or general practice? 31–33
 Varnam M and Sackin P: The benefits of a National Symposium (N) 519
 Vercoe S: General practitioners' responses to government proposals (C) 511
 Vincent CA and Richardson PH: Acupuncture for some common disorders: a review of evaluative research 77–81

W

- Waine C: Healthcall and the College (C) 465
 Walker B: *see* Walker R
 Walker E, Cossar JH, Dewar RD and Reid D: Computerized advice on malaria prevention and immunizations (C) 223
 Walker FS: *see* Fraser RC

- Walker R: The cost of being a Council faculty representative (N) 477
 Walker R and Walker B: Use of the objective structured clinical examination for assessment of vocational trainees for general practice 123–124, (C) 275
 Walker R: *see* Jones K
 Wall DW: Ethics and the pharmaceutical industry: some ideas for general practitioners 267–269
 Wallace P: *see* Price EM
 Wallace PG, Brennan PJ and Haines AP: Drinking patterns in general practice 354–357
 Walpole GA: *see* Burrows PJ
 Walton R: Azapropazone in the treatment of gout (C) 561
 Walton RJ: *see* Burrows PJ
 Ward JA: Cancer screening (C) 510
 Warnock PJ: *see* Calder BD
 Waterston T and Van Zwanenberg T: Integration of community medicine and primary care (C) 368
 Watkins CJ, Papacosta AO, Chinn S and Martin J: A randomized controlled trial of an information booklet for hypertensive patients in general practice 548–550
 Watkins J: Screening for tuberculosis — a possible transmission route of HIV (C) 273
 Weedle PB, Poston JW and Parish PA: Survey of remedies held and dispensed in residential homes for the elderly 412–413
 Weleminsky J: Prison medicine (C) 425
 Wells F: Promotion by the drug companies — the industry replies 271
 West RR: *see* O'Dowd TC
 Whitehouse CR: A survey of the management of psychosocial illness in general practice in Manchester 112–115

- Whitney JDW: Membership for established principals (C) 371
 Wickins MC: *see* Jones RVH
 Wilkin D: Patterns of work in general practice (C) 322
 Wilkin D and Smith AG: Variation in general practitioners' referral rates to consultants 350–353
 Wilkinson J: Nursing homes (C) 84–85
 Williams EI and Wilson AD: Health care units: an extended alternative to the Cumberlege proposals 507–509
 Williams P: The age of the computer? (C) 180
 Willis E: Rural hospitals in South Africa (C) 133–134
 Wilmot JF: 'There's a lot of it about' (C) 84
 Wilson A: The red eye: a general practice survey 62–64
 Wilson AD: *see* Williams EI
 Wilson D: *see* Burrows PJ
 Wilson MS: Coxsackie or brucella? (C) 318–319
 Wilson MS: Sexual abuse of children (C) 416
 Wilton J: *see* Longhurst HJ
 Wilton J: *see* Price EM
 Wood SM and Mann RD: Post-marketing surveillance of enalapril (C) 514
 Woodbine S: *see* Burrows PJ
 Wookey CB: Post-viral syndrome (C) 370
 Wooton G: *see* Haslett S
 Wright AF and Perini AF: Hidden psychiatric illness: use of the general health questionnaire in general practice 164–167

Y

- Young JD: Long term benzodiazepine use (C) 320–321
 Youngs H: *see* Campbell M

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Published by The Royal College of
General Practitioners, 14 Princes
Gate, London SW7 1PU.
Editorial Office: 8 Queen Street,
Edinburgh EH2 1JE.
Printed in Great Britain by
Thomas Hill Print (1985) Ltd.,
Bishop Auckland, Co. Durham DL14
6JQ.

Extended residential courses

THE MSD Foundation runs extended residential courses for young general practitioners which are aimed at helping future leaders in the field of postgraduate medical education. The weekly medical press has commented on the 'elitist' nature of the courses, but the Foundation is not the first body to attempt to influence general practice through the medium of a relatively small number of participants attending extended courses. In the early 1970s the Royal College of General Practitioners ran the Nuffield courses (supported by the Nuffield Provincial Hospital Trust) which were influential in the implementation of vocational training for general practice, and in the late 1970s the Scottish Council for Postgraduate Medical Education¹ ran a smaller course aimed at potential regional and associate advisers in Scotland. The Nuffield courses have been well described² and their small group methods have subsequently been employed in vocational training throughout the country. Most of the participants of the Nuffield courses have become actively involved in medical education.

What are the benefits of the extended residential course? Meeting tutors and other members of the course over a relatively long time period and focussing attention on personal qualities and skills produces a learning experience which cannot be achieved in the usual forms of continuing education. The small group approach of the Nuffield and the MSD Foundation courses fosters the creation of a bond of trust between participants which enables them to reveal and understand their personal approach to patient care. The main drawback of extended courses is also their chief advantage — the time that course members are away from their practices. It is of interest that the duration of extended courses has decreased from the 30 days of the Nuffield courses, to the 20 days of the extended courses in Scotland and finally to the nine days of the MSD Foundation leadership courses. All the courses require work to be carried out between the short residential sessions.

General practice is an evolving discipline with times of rapid change such as the periods following the Charter of 1965 and the introduction of mandatory vocational training in 1980. We are now once again in a state of flux. This time the issue is not between single handed practice and group practice or whether a general practitioner should undergo special training before being allowed to become a National Health Service principal but rather how to ensure that everyone receives a high quality of service from his or her general practitioner. The College's policy statement *Quality in general practice*³ and the Government's green paper⁴ have made specific proposals for change, designed to improve the quality of care in general practice. It is against this background of change that the MSD Foundation has developed its leadership courses.

One aim of the MSD Foundation courses is to help participants to understand motivation, whether it be of self or of others. In the past the price of leadership has been substantial in terms of its effect on the participant's practice and on his family. Recognizing these costs may allow more realistic roles to be developed for future leaders in general practice which will demand less family sacrifice than was considered normal in the past.

burns in a bomb blast below decks on *Sir Galahad*, and was the only survivor from one of the stern compartments. His face, hands and scalp were especially affected. Following emergency surgery on the hospital ship *SS Uganda*, he was air-lifted back to Britain and underwent a protracted course of plastic surgery and physiotherapy.

He received tremendous support from his family and neighbours in his Welsh village, but broke off his engagement to an English girl. He seemed to feel that local people would judge him by his former self, whereas in a strange place he would be seen as no more than a crippled soldier with bad facial scars. He became moody, irritable and sleepless, frequently quarrelling with his mother, who was his main support. He drank to excess, and it was only when drunk that he could talk of his guilt at surviving. While drunk he revealed that his worst hand burns were sustained as he attempted to push his burning friends to safety but that he had had to leave them eventually.

Discussion

These three young men presented with neurotic disorders which had many features in common, and began six months or more after unusually severe life-threatening stress. They suffered from a mixture of anxiety and depression with some somatic symptoms, frequent flashbacks to their experiences, and guilt at having survived. They also showed difficulty in grieving over lost comrades and their irritability led to family and employment problems. This syndrome corresponds to the American description of delayed post traumatic stress disorder and follows the pattern described by Black in a study of more than 1000 Vietnam war veterans.⁴

Only Case 2 had had previous psychiatric illness, for which he had been successfully treated and passed fit for active service. All three had resorted to alcohol to suppress their symptoms and 'Simon' could only talk of his experience under the influence of alcohol.

That we came across these cases by chance suggests that they may well represent the tip of the iceberg. The comfortable conclusion that the Falklands war had remarkably few psychiatric casualties is not tenable.

One possible contributory factor is the psychological ambience of the armed forces. Preparation for battle involves instillation of a sense of *esprit de corps*, so that the soldier, especially the young recruit, is more concerned at loss of face before his comrades than the prospect of his death or mutilation. However, this sense of group identity leads to a severe sense of bereavement when a soldier loses comrades and the normal resolution of grief through weeping is likely to be discouraged.

In addition, all three of the cases reported here found it impossible to report emotional distress to a service doctor, who is inevitably handicapped by his position in the service hierarchy. We found it surprising that despite the work of army psychiatrists 40 years ago on the importance of front-line diagnosis and treatment of war neuroses (including acute abreaction⁵), there were no Royal Army Medical Corps psychiatrists in the Falklands war.¹

Heavy use of alcohol is a feature of Army and Navy mess life, and is encouraged by the policy of keeping prices low in the NAAFI. The low price of cigarettes has already been commented on as a factor in the high rate of early cardiovascular disease in the Army.⁶ The use of alcohol as a do-it-yourself tranquillizer is likely to perpetuate a grief reaction, and confuse its diagnosis and treatment. This is evident in all three of the cases reported here.

It is important that the delayed psychiatric casualties of the Falklands war are identified so that appropriate help can be offered. It is also important that general practitioners know of the sources of such help, in particular of the Ex-Services Mental Welfare Society, which is able to advise on war pension rights.

However, the only way to ascertain the true prevalence of psychiatric casualties of the Falklands war among serving soldiers and their relatives is by epidemiological studies.

In any future conflicts it would appear essential to provide an acute counselling service after these life-threatening experiences, as did Stöfsl⁷ in Holland after passengers were held hostage on a train. After their first taste of combat young people need somewhere to express their feelings, somewhere free of the limitations of discipline, free of the constraints on weeping and free of the harmful effects of heavy alcohol use.

Owing to his civilian status, the general practitioner is in a unique position to assess and treat these psychiatric casualties and if necessary refer them for specialist opinion.⁸ It is likely that further problems will present for some years to come.

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Address for correspondence

Dr G.H. Jones, Department of Psychological Medicine, University of Wales College of Medicine, Whitchurch Hospital, Cardiff CF4 7XB.

Fansidar in malaria prophylaxis

Prophylactic advice for visitors to areas endemic for chloroquine-resistant falciparum malaria is already difficult, and the problem has been increased by recent evidence on the frequency of side-effects to Fansidar (pyrimethamine, Roche).

A survey in the USA showed that several deaths due to Stevens-Johnson syndrome, erythema multiforme or toxic-epidermal necrolysis had occurred in those taking Fansidar since the drug became available on the American market in 1982. The fatality rate is estimated to be between 1 in 18 000 and 1 in 26 000, in those receiving Fansidar in the USA. Such a level is unacceptably high for a prophylactic under most circumstances, and has led the USA to suggest the use of chloroquine for short-term visitors even to chloroquine-resistant *P. falciparum* areas, with a curative dose of Fansidar in the pocket, and to leave a wide range of options open for the long-term visitor to such areas.

On the basis of what is known or implied by the information at present available, it would appear advisable not to recommend Fansidar to visitors to areas of chloroquine-resistant *P. falciparum* malaria, where Fansidar or Maloprim was recommended in the past, at least until further information becomes available.

Source: PHLS Communicable Diseases Surveillance Centre. Fansidar in malaria prophylaxis. *Communicable Disease Report* 1985; weekly edition 85/20: 1.

the patient wants but hardly anything of what the patient needs. On the other hand, British general practice may go flirting with a fee-for-item-of-service system just at the time when North America and Australia will be coming more and more to realize the benefits of a pre-paid service.

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Address for correspondence

Professor M. Kamien, Department of Community Practice, University of Western Australia, 328 Stirling Highway, Claremont, WA 6010, Australia.

Predicting complications in coronary care

The use of the initial electrocardiogram as a predictor of complications was evaluated in 469 patients with suspected acute myocardial infarction. An electrocardiogram was classified as positive if it showed one or more of the following: evidence of infarction, ischaemia, or strain; left ventricular hypertrophy; left bundle-branch block; or paced rhythm. Life-threatening complications were 23 times more likely if the initial electrocardiogram was positive ($P<0.001$). Other complications were 3 to 10 times more likely ($P<0.01$), interventions were 4 to 10 times more likely ($P<0.05$), and death was 17 times more likely ($P<0.001$) in patients with a positive electrocardiogram.

The authors conclude that patients with a negative initial electrocardiogram have a low likelihood of complications and could be admitted to an intermediate care unit instead of a coronary care unit. This would reduce admissions to the coronary care unit by 36% and thereby save considerable hospital costs without compromising patient care.

Source: Brush JE, Brand DA, Acampora D, et al. Use of the initial electrocardiogram to predict in-hospital complications of acute myocardial infarction. *N Engl J Med* 1985; 312: 1137-1141.

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